Appendix 2

Wisconsin Medicaid Home Care Assessment Form

1. Provider Information

1.1 Provider Name: _____

1.2 Medicaid Provider Number: _____

1.3 Provider's Fax Number: _____

2. Recipient Information

2.1 Name (Last, First, Middle Initial): _____

2.2 Medicaid ID Number: _____

2.3 Physical address where home care services are provided: _____

2.4. Does the recipient have any private insurance? ☐No ☐Yes

(If yes, bill the private insurance before billing Medicaid. However, providers should request Medicaid prior authorization for all Medicaid covered services, including those services billed to other payers.)

2.5 Does the recipient have a Medicare card? ☐No ☐Yes

If yes, check the applicable box: ☐ Part A only ☐ Part B only ☐ Parts A and B

2.6 Is the recipient confined to his/her residence? ☐No ☐Yes

([HFS 101.03(31), Wis. Admin. Code] A recipient does not need to be confined to the residence in order to receive Medicaid-covered home health aide (HHA) or personal care worker (PCW) services. A recipient must be confined to the residence in order to receive Medicaid-covered home health nursing or home health therapy, unless the skilled service cannot be reasonably obtained through another, more appropriate provider. [Refer to the Home Health Handbook for additional information.])

Recipient name_____

2.7 Does the recipient need any of the following skilled services? ☐No ☐Yes

☐RN ☐LPN ☐PT ☐OT ☐ST

(If a recipient is eligible for Medicare, is confined to the residence, and needs a skilled service, Medicare must be maximized before Medicaid is billed, including supplies and equipment. However, request Medicaid prior authorization for all Medicaid-covered services, including those billed to other payers.)

2.8 Does the recipient require home care services as the result of:

A. Motor vehicle accident: ☐No ☐Yes
B. Employment-related accident: ☐No ☐Yes
C. Other accident: ☐No ☐Yes

2.9 Does the recipient receive county funding? ☐No ☐Yes

If yes, complete the following:

☐Community Options Program
☐Medicaid waivers (CIP IA, IB, II, COP-W)
☐Other (specify):_____
☐Unknown

3. Responsible Party

3.1 Does the recipient have a legal guardian, person with power of attorney, or other responsible party who must be contacted, or who the recipient wants contacted, with issues regarding the recipient's care: ☐No ☐Yes

If yes, complete the following:

Name and relationship: _____

Address: _____

Telephone Number:_____

Recipient name_____

4. Other Service Providers

4.1 Does the recipient receive case management services? ☐ No ☐ Yes

If yes, complete the following:

Case Management Agency:_____

Address:_____

Telephone Number:_____

4.2 Will the recipient also receive home care services from another provider?

☐ No ☐ Yes

If yes, please provide the following to assist in the coordination of services.

Type of Provider	Name	Street Address	City, State, Zip	Telephone
Home health or personal care				
Paid individual (e.g., COP worker)		N/A	N/A	N/A
Legally responsible spouse or parent		N/A	N/A	
Unpaid household members		N/A	N/A	N/A
Other provider				

(Medicaid cannot be billed for parenting or services a family member or volunteer is willing to provide free of charge.)

5. Scheduled Activities Outside of Residence

5.1 Does recipient attend scheduled activities outside of the residence? ☐ No ☐ Yes

If yes, provide the recipient's schedule:

Scheduled Activity	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
School							
Work							
Day Program							
Other							

Recipient name_____

6. Living Arrangement

6.1 Recipient's housing is:

☐ Accessible
☐ Not accessible to wheelchairs and assistive equipment

6.2 Recipient's living arrangement:

☐ Alone (Go to 7.1)
☐ With family, friend, roommate with no legal responsibility (Go to 7.1)
☐ With legally responsible adult (spouse or parent of minor child) (Go to 7.1)
☐ Foster Home: Name of Foster Parent/Sponsor:
☐ Community-Based Residential Facility (CBRF): Name:
☐ Other (specify): _____ (Go to 7.1)

6.3 If recipient resides in a foster home or CBRF, how many people reside there?

☐ 1-2 ☐ 5-8 ☐ 16-20
☐ 3-4 ☐ 9-15 ☐ More than 20

(Medicaid does not cover services included in the CBRF's daily rate or personal care services in a CBRF with more than 20 beds.)

6.4 List and explain any social, economic, or cultural factors not otherwise identified that may impact on the need for home care services or how the services are provided:

_____

_____

7. History of Condition

7.1 Explain in the space provided, recipient's condition and any past or present problems which directly affect the delivery of home care services at this time:

_____

_____

_____

_____

Recipient name_____

_____

_____

_____

_____

_____

_____

7.2 List each diagnosis by ICD-9-CM diagnosis code and description, and date of onset for which care is required:

_____

_____

7.3 How long do you anticipate the recipient will require ongoing home care services?

☐ Indefinitely ☐ More than 12 months
☐ 12 months ☐ Less than 12 months

7.4 Is there potential for the recipient to learn how to perform self-care?

☐ Yes ☐ But only somewhat, or ☐ Only at an appropriate age
☐ No
☐ No opinion

8. General Assessment Information

8.1 Communication

How does the recipient make his/her needs known:

☐ 0 = Communicates needs.
☐ 1 = Communicates with difficulty but can be understood.
☐ 2 = Communicates with sign language, symbol board, written messages, gestures, or interpreter.
☐ 3 = Communicates inappropriate content, makes garbled sounds.
☐ 4 = Does not communicate needs.
☐ N = Child with age appropriate communication.

8.2 Hearing

Does the recipient wear a hearing aide? ☐No ☐Yes

Code recipient's ability to hear with hearing aid if customarily worn:

☐0 = No hearing impairment.
☐1 = Hearing difficulty at level of conversation.
☐2 = Hears and understands only very loud sounds, e.g., has to be yelled at.
☐3 = No useful hearing, including unable to interpret audible sounds.
☐4 = Not determined.

8.3 Vision

Does the recipient use corrective lenses? ☐No ☐Yes

Code recipient's ability to see with corrective lenses if customarily worn:

☐0 = Has no impairment of vision.
☐1 = Has difficulty seeing at level of print, but may be able to read large or thick print.
☐2 = Has difficulty seeing obstacles in environment.
☐3 = Has no useful vision.
☐4 = Not determined.

8.4 Orientation

Orientation is awareness to the present environment in relation to time, place, and person:

☐0 = Oriented.
☐1 = Minor forgetfulness of:
☐time ☐place ☐person ☐medications ☐meals
☐2 = Partial or intermittent periods of disorientation in:
☐AMs ☐PMs ☐2 hours or less ☐consistently ☐inconsistent times
☐3 = Totally disoriented; does not know time, place, identity.
☐4 = Comatose.
☐5 = Not determined.

Recipient name_____

9. Behavior/Challenging Behavior

9.1 Behavior

Use the code that best describes the recipient's behavior. The behavior should be considered within the context of the environment, age, and the life circumstance of the recipient before coding as a "problem." Consider unpredictability, severity, and frequency of the behavior.

- ☐ 0 = Fully cooperative.
- ☐ 1 = Needs prompts/assistance/encouragement to initiate personal care/treatment due to behavior, including noncompliance, but no assistance once care/treatment has begun.
- ☐ 2 = Needs prompts/assistance/encouragement intermittently during personal care/treatment due to behavior, including noncompliance.
- ☐ 3 = Needs consistent, ongoing support/assistance/encouragement throughout duration of personal care/ treatment due to behavior, including noncompliance.
- ☐ 4 = Exhibits one or more of the challenging behaviors under 9.2 less than daily.
- ☐ 5 = Exhibits one or more of the challenging behaviors under 9.2 daily.
- ☐ N = Age appropriate (only for children less than five years old).

Comments: _____

_____

9.2 Challenging Behavior

Only complete this section if the recipient is rated a "4" or "5" under Section 9.1, Behavior. These behaviors may occur in addition to behavior(s) described under Section 9.1, Behavior.

- ☐ 1 Self Injurious Behavior: Engages in behavior that causes injury or has potential for causing injury to his/her own body. Examples include self-hitting, self-biting, head-banging, self-burning, self-poking, or stabbing, ingesting foreign substances, or pulling out hair.
- ☐ 2 Unusual/Repetitive Habits: Performs unusual stereotypic behavior that inhibits or prohibits participation in daily life activities. Examples include head-weaving, rocking, grinding teeth, spinning objects, or hand-flapping. Collects and hoards items to a point where it interferes with participation in normal daily activities.

Recipient name_____

☐ 3 Withdrawal Behavior: Excessively avoids others or situations calling for personal interaction to a point where this behavior significantly interferes with participation in normal daily activities. Examples include refusing to talk to others, remaining in his/her room for inordinate periods of time, repeatedly declining opportunities to recreate with others, extreme passivity which leads to victimization.

☐ 4 Hurtful to Others: Engages in behavior that causes physical pain to other people or to animals. Examples include hitting, biting, pinching, scratching, kicking, and inappropriate sexual contacts.

☐ 5 Socially Offensive Behavior: Behavior offensive to others or that interferes with the activity of others. Examples include spitting, urinating in inappropriate places, stealing, screaming, verbal harassment, bullying, and masturbating in public places.

☐ 6 Destruction of Property: Damages, destroys, or break things. Examples include breaking windows, lamps, or furniture; tearing clothes; setting fires; using tools or objects to damage property.

☐ 7 One-on-One Supervision for Self Preservation: Requires constant one-to-one supervision due to behavior for self preservation. *Supervision of the recipient when supervision is the only service provided at the time is not covered by Medicaid.* (For medically necessary one-to-one observation, refer to 11.2, Observation.)

Self preservation is not to be assessed for children less than four years of age because they are dependent on parents by nature of age to ensure their safety. If the child requires more assistance than an adult would typically provide for the child's age, evaluate the child.

If #7 is checked, how frequently does the recipient require one-on-one supervision for self preservation? (Check one)

☐ Less than once a month
☐ 1-4 times per month
☐ 4+ times per month, not daily
☐ Daily, but not hourly
☐ Hourly (one or more per hour during at least 8 hours per day)

Comments: _____

_____

Recipient name_____

10. Activities of Daily Living (ADL)

10.1 Dressing

Dressing, such as changing from pajamas to clothes and back to pajamas. Includes application of TED or support hose, but not application of prosthetics or orthotics.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to dress. (Record for person who receives assistance to lay out clothes, fasten clothes, or whose performance must be monitored.)

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help and presence of another person during all of this activity. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

10.2 Grooming

Grooming, including combing or brushing (but not washing) hair, shaving, brushing/flossing teeth or cleaning dentures, nail care, applying deodorant, inserting and removing contact lenses, inserting and removing hearing aids, and feminine hygiene. Rank based on ability to perform grooming in general, not on ability to perform specific tasks.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminders or instruction, but does not need physical presence of another person at all times to groom.

☐ 2 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 3 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 4 = Dependent on Another: Needs and receives physical help from other person to carry out this activity. Recipient is unable to physically participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

10.3 Bathing

Bathing or washing the recipient, whether tub, shower, or bed bath. Includes entering tub or shower, wetting, soaping, and rinsing skin and hair, exiting, drying body, and lotioning of skin.

☐ 0 = Independent: Does not need help or supervision of another person in any part of this activity.

☐ 1 = Intermittent Supervision: Needs and receives occasional reminder or instruction, but does not need physical presence of another person at all during bath.

☐ 2 = Needs and receives help in and out of the tub, but can bathe self.

☐ 3 = Constant Supervision: Needs and receives help of another person constantly present during this activity to instruct or watch for problems, but does not need physical help.

☐ 4 = Help of Another: Needs and receives physical help. Recipient is able to physically participate.

☐ 5 = Dependent on Another: Needs and receives physical help from other person to carry out washing and/or drying. Recipient is physically unable to participate.

☐ N = Age Appropriate: Only for children less than five years old.

Comments: _____

_____

Recipient name_____

10.4 Eating

Eating is the process of getting food into the digestive system. Meal preparation is excluded.

- ☐ 0 = Independent: Eats without help of any kind (drinks from glass and cuts food).
- ☐ 1 = Independent: Eats without help of any kind (drinks from glass and cuts food), but requires assistance in preparing the meal.
- ☐ 2 = Needs and receives personal supervision (reminders) or programming in eating.
- ☐ 3 = Needs and receives assistance to cut meat, arrange food, butter bread, etc., at meal time.
- ☐ 4 = Needs and receives partial feeding from another person (includes drinking from a cup or observation for choking due to frequent incidents of more than once a week).
- ☐ 5 = Needs and receives total feeding from another person.
- ☐ 6 = Needs and receives tube feeding from another person.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments (include information about any special diet): _____

_____

10.5 Transfers

Transfer is the process of moving between positions (i.e., to/from bed, chair, standing). Transfers for bathing already covered in Section 10.3.

- ☐ 0 = Independent: Requires no supervision or physical assistance to complete necessary transfers. May use equipment such as railings and trapeze.
- ☐ 1 = Intermittent Supervision: Needs and receives guidance only. Requires physical presence of another person during transfer (i.e., verbal cueing, guidance).
- ☐ 2 = Needs and receives physical help from another when transferring. Recipient may participate.
- ☐ 3 = Needs and receives physical help from another or mechanical device. Recipient is unable to participate.
- ☐ 4 = Remains bedfast.
- ☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

_____

Recipient name_____

10.6 Mobility

Mobility is the process of moving between locations (i.e., bedroom to living room).

☐ 0 = Independent: Ambulatory without a device.

☐ 1 = Needs and receives help of a device, such as cane, walker, crutch, or wheelchair, and is:
A) Independent in its use ____. B) Needs supervision (cueing or guidance) to use it ____

☐ 2 = Needs and receives physical help from another person. Includes negotiating stairs or home ramp; to lock and unlock wheelchair brakes.

☐ 3 = Needs and receives constant physical help from another person. Includes total dependence with moving wheelchair.

☐ 4 = Remains bedfast.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

_____

10.7 Positioning

Positioning includes changing body position at a specific location (i.e., sitting up or turning over in bed).

☐ 0 = Positions self in bed or chair without help.

☐ 1 = Needs and receives occasional help from another person to sit up.

☐ 2 = Always needs and receives help from another person to sit up.

☐ 3 = Needs and receives turning and positioning.

☐ N = Age Appropriate: Only for children less than 15 months.

Comments: _____

_____

Recipient name_____

10.8 Toileting

Bowel and bladder elimination, including use of toileting equipment, such as commode, cleansing self after elimination, and adjusting clothes.

☐ 0 = Independent: Needs no supervision or physical assistance (includes recipient manages dribbling or incontinence).

☐ 1 = Intermittent Supervision: Needs and receives intermittent supervision or programming for safety or encouragement, or minor physical assistance (e.g., clothes adjustment or washing hands). No incontinence.

☐ 2 = Occasional incontinence, not more than once a week.

☐ 3 = Usually continent of bowel and bladder, but needs and receives supervision and/or physical assistance with major parts or all parts of the task, including bowel and/bladder programs and appliance (i.e., colostomy, ileostomy, urinary catheter, bed pan, incontinent product used as precaution).

☐ 4 = Incontinent of bowel and/or bladder, and is not taken to bathroom (includes person who uses incontinent product and is not toileted or catheterized).

☐ 5 = Incontinent of bowel and/bladder, but is taken to a bathroom or put on bed pan every two to four hours during the day and as needed during the night.

☐ N = Age Appropriate: Only for children less than three years old.

Comments: _____

_____

11. Medically Oriented Tasks

Check all medically oriented tasks for which the recipient requires care. We expect that the recipient and family members will be taught to perform these tasks when possible. Some of the interventions listed below are routinely delegated to a home health aide (HHA) or personal care worker (PCW), while others are rarely delegated. It is the responsibility of the supervising nurse to be knowledgeable about delegation regulations under the Nurse Practice Act. Indicate the level(s) of caregiver that will provide the care.

11.1 ☐ Seizures

A. Has the recipient had a seizure in the past 12 months? ☐ No ☐ Yes

B. Does the recipient require active seizure intervention for uncontrolled seizures?

☐ No ☐ Yes

Interventions:

☐ Take measures to protect from physical harm.
☐ Administer preselected medication.
☐ Administer sliding scale medication.
☐ Other, explain:_____

Who provides the intervention?

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. If the recipient has a diagnosis of seizures, please complete the following:

Specific seizure type: _____

Frequency of seizures (Per Day, Per Week, or Per Month): _____

Date of last seizure:_____

Date seizure medication last administered: _____

11.2 ☐ Observation: Observation may be medically necessary when there is a likelihood that immediate medical attention will be required at unpredictable intervals due to the recipient's medical condition. For example, a recipient with active seizures not controlled by medication may require observation. Does not include supervision for physical safety of cognitively impaired or self-destructive persons (see 9.2, Challenging Behavior), or age appropriate supervision of children (i.e., babysitting).

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.3 ☐ Daily Tube Feedings:

☐ Nasogastric ☐ Gastrostomy ☐ Other: _____
☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

 Recipient name_____

11.4 ☐ Daily Parenteral Therapy: May include intravenous medication, Hickman Catheter, or Heparin lock.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.5 ☐ Wound or Decubiti Care: May include wound or decubitus dressing and care, ostomy dressing, and warm moist packs for inflamed areas.

Wound Stage/Grade: ☐ I ☐ II ☐ III ☐ IV

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.6 ☐ Tracheostomy Care/Suctioning:

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.7 ☐ Oxygen and Respiratory Therapy: Special measures to improve respiratory function, including postural drainage, percussion, blow bottles, IPPB, respirators, suctioning, and oxygen. Excludes standby oxygen unless actually administered weekly.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.8 ☐ Catheters: Routine care is provided at least daily. Include indwelling catheters and intermittent catheterization and dressing of a suprapublic catheter.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.9 ☐ Ostomies: Routine care provided. Include colostomy, ileostomy, ureterostomy, or cystostomy.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.10 ☐ Bowel Program: Bowel program is provided at least two days per week.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Recipient name_____

11.11 ☐ Therapy Program: Recipient receives assistance with therapy, including range of motion, under a therapy plan prescribed by a Physical Therapist, Occupational Therapist, or Speech and Language Pathologist within 12 months.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.12 ☐ Application/Maintenance of Prosthetics and Orthotics: Application of a prosthesis or orthosis as part of a serial splinting program or when the recipient has a demonstrated problem with frequent skin breakdowns which must be closely monitored.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.13 ☐ Complex Positioning: Positioning to reduce spasticity or positioning a recipient who would require complex repositioning when he or she has a demonstrated problem with frequent skin breakdowns; or is part of a therapy treatment program requiring specialized positioning.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.14 ☐ Complex Transfers: Complex transfers are transfers that require the use of special devices when there is an increased likelihood that a negative outcome would result if the transfer is not done correctly, or when a special technique is used as part of a complex therapy program, and the recipient has no volitional movement below the neck, or when simple transfer techniques have been demonstrated to be ineffective and unsafe.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.15 ☐ Complex Feeding: Feeding with special technique or tools when there is a potential for aspiration and physician orders state special procedures or tools must be used for safe feeding. (Thickening of liquids or small bolus of food positioned in special section of mouth.)

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.16 ☐ Glucometer Reading: Taking glucometer readings and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of readings outside of parameters established by the physician.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Recipient name_____

11.17 ☐ Vital Signs: Taking vital signs and reporting to the supervising RN when the recipient's medical history supports the need for ongoing monitoring for early detection of an exacerbation and the physician establishes parameters at which point a change in treatment may be required.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.18 ☐ Skin Care: Skin care when legend solutions, lotions, or ointments are ordered by the physician due to skin breakdown, wounds, open sores, etc. Does not include PRN or prophylactic skin care, which is an activity of daily living task.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

11.19 ☐ Medication Assistance: Check all boxes that apply.

A. ☐ Recipient requires assistance taking medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

B. ☐ Recipient requires administration of medications. "Administer" is the direct application of a prescription drug or device, whether by injection, ingestion, or any other means, to the body of a patient.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

C. ☐ Recipient requires medications to be set up because no pharmacy in the area or no family/volunteers are willing to set up the medications.

☐ RN/LPN ☐ HHA ☐ PCW ☐ Other: _____

Comments: _____

_____

Recipient name_____

D. In the table, list all legend medications prescribed for the recipient at the time you complete this assessment form, OR attach a separate medication list, such as the HCFA 485. *This information is required even if your agency does not administer or assist with administration.* Include the dosage, frequency, route, and start and stop dates.

Medication Name	Dosage/Frequency	Route	Start/Stop Dates

E. If the recipient has any drug, food, or other allergies, please list them:

_____

_____

_____

11.20 Other Task/Problems Not Listed:

Document any other problems which support the need for home care services and the justification for the time which is required to provide the services. Clearly document the intervention. Additional pages may be attached.

_____

_____

_____

_____

12. Staffing

12.1 Anticipated Staffing: Show the scheduled times (e.g., 8:00-10:00 a.m.) that each agency will provide services and indicate funding source. Staffing may vary on a day-to-day basis at the convenience of the recipient. Agencies cannot vary schedule times without the approval of the recipient.

Level of Care	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Skilled Nursing							
Home Health Aide							
Personal Care Worker							
Case Share w/ ABC							
Other (Specify) COP Worker							
Other (Specify)							

Recipient name_____

Recipient name_____

12.2 Is this amount of staffing expected to change within 12 months? ☐ No ☐ Yes

If yes, why? _____

_____

12.3 Other clarification on staffing, such as the reason why more than one home health aide visit, or a combination of home health aide and personal care services must be provided in a day when the home health aide visit does not equal four hours for an initial or three hours for subsequent visit:

_____

_____

_____

_____

13. Physician's Orders

CARE IS COVERED ONLY WHEN ORDERED BY A PHYSICIAN. Providers do not need to wait for signed orders to send in prior authorization requests to Wisconsin Medicaid. The unsigned orders/POC may be sent in prior to obtaining the physician's signature. However, the orders/POC must be signed by the physician and placed in the recipient's record within 20 days. When a case is ongoing and care will be continued, new physician's orders must be in place before the previous orders expire. Services provided without properly documented orders are subject to recoupment. Licensed and Medicare-certified home health agencies should refer to their licensing and certification requirements regarding physician orders.

14. Wisconsin Medicaid Reimbursement Policy

AN APPROVED AUTHORIZATION DOES NOT GUARANTEE PAYMENT. Reimbursement is contingent upon eligibility of the recipient and provider at the time the service is provided and the completeness of the claim information. Payment will not be made for services initiated prior to approval date or after authorization expiration date. Reimbursement will be in accordance with Wisconsin Medicaid program payment methodology and policy. If the recipient is enrolled in a Wisconsin Medicaid contracted managed care program at the time prior authorized service is provided, Wisconsin Medicaid program reimbursement will be allowed only if the service is not covered by the managed care program.

Recipient name_____

15. PCW, HHA, and Travel Time Services

15.1 Total Paid PCW and HHA Services:

A. Medicaid PCW care hours/week requested by this provider (from PA/RF): _____

B. Medicaid PCW hours/week from case sharing provider (obtain this information from case sharing provider): + _____

C. HHA hours/week requested from your agency (any payer) (HHA initial visit may = up to 4 hours if medically necessary; HHA subsequent visit may = up to 3 hours if medically necessary): + _____

D. HHA hours/week from any provider (any payer) (HHA initial visit may = up to 4 hours if medically necessary; HHA subsequent vist may = up to 3 hours if medically necessary): + _____

15.2 A. TOTAL Hours: 15.1, A + B + C + D = _____

B. Number of days care will be provided per week: _____

C. PCW travel time/week requested by the provider (from PA/RF): _____

16. Signatures

16.1 As the RN, I certify that this assessment is a true, accurate, and complete reflection of this recipient's care needs. This assessment was completed by a registered nurse or case manager in coordination with the registered nurse. Either the recipient or the recipient's responsible party was allowed to participate in the assessment. Medically necessary care will be provided in accordance with the recipient's assessed needs.

RN completing this form: _____
print

_____
signature date

16.2 I have participated in this assessment. This is a true description of my care needs, or the recipient's care needs, when the signee is the responsible party.

Recipient or Responsible Party: _____
print

_____
signature date

(The signature is not required for submission of the prior authorization request, but must be obtained within 62 days of the assessment and maintained on file.)